Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

DIVISION OF DEVELOPMENTAL DISABILITIES

PLANNED ACTION NOTICE
WAIVER ENROLLMENT AND TERMINATION

CLIENT NAME AND ADDRESS

REPRESENTATIVE NAME AND ADDRESS

DDD has made a determination regarding your enrollment in a DDD Home and Community Based Services Waiver.

WAIVER ENROLLMENT

☐ You are approved to be enrolled in the following DDD HCBS Waiver:

- ☐ Basic
- ☐ Basic Plus
- ☐ CORE
- ☐ Community Protection

The effective date of enrollment for this waiver is: _____ .

You may call your Case/Resource Manager (CRM) for further information and planning.

CRM NAME	TELEPHONE NUMBER

WAIVER TERMINATION

☐ You are no longer eligible for participation in the following DDD HCBS Waiver:

☐ Basic ☐ Basic Plus ☐ CORE ☐ Community Protection

The effective date of this termination for waiver eligibility and services is: _____ .

The reason(s) for this termination:

☐ You do not meet waiver eligibility criteria.	WAC 388-845-0030
☐ You are being enrolled in a different DDD HCBS waiver.	WAC 388-845-0045; 0080; 3085
☐ You no longer need or use waiver service.	WAC 388-824-0030(6) or 0060(2)(3)
☐ You are in the Community Protection waiver and choose not to be served by a certified Community Protection Provider.	WAC 388-845-0060(4)
☐ You choose to disenroll from the waiver.	WAC 388-845-0060(5)
☐ You reside out-of-state.	WAC 388-845-0060(6)
☐ You cannot be located or do not make yourself available for the annual waiver reassessment of eligibility.	WAC 388-845-0060(7)
☐ You refuse to participate in your service planning, or quality assurance or monitoring activities.	WAC 388-845-0060(b)(c)
☐ You are refusing services agreed to in your plan of care as necessary to meet your health and safety needs.	WAC 388-845-0060(c)
☐ You are residing in an institution.	WAC 388-845-0060(9)
☐ Your needs exceed what can be provided under your waiver.	WAC 388-845-0000 or 3085

DISTRIBUTION: Regional Waiver Coordinator Client File

YOUR APPEAL RIGHTS

You have the right to ask for an Administrative Hearing if you disagree with the termination of waiver eligibility.

If your waiver termination is solely due to your ineligibility for Medicaid or Social Security disability, there is no right to appeal against DDD. Your appeal rights are with the agency that made the decision of ineligibility.

You have ninety (90) days from the receipt of this notice to appeal this action.

- If you are currently receiving paid waiver services from DDD and want waiver eligibility and services to continue during your appeal, you must file your request for an administrative hearing by:

  _____

- If you choose to continue paid services and the final decision upholds the department's action, you will be responsible to repay up to 60 days of paid services.
- If you do not want your paid services to continue, contact:

_____ at _____

CASE/RESOURCE MANAGER | TELEPHONE NUMBER

You have the following rights:

1. To be represented (you may be eligible for free legal assistance):
2. To request a copy of your file and all information reviewed by DDD to make its decision;
3. To submit documents into evidence;
4. To testify at the hearing and to present witnesses to testify on your behalf; and
5. To cross examine witnesses testifying for the department.

A form for requesting an administrative hearing is enclosed.

DO YOU HAVE QUESTIONS?

If you have questions about this decision or appeal process, please contact

NAME	TELEPHONE NUMBER	LOCAL OFFICE

Washington State Department of Social & Health Services

DDD Division of Developmental Disabilities

PLANNED ACTION NOTICE DDD WAIVER ENROLLMENT AND TERMINATION REQUEST FOR HEARING

per Chapter 388-02 for DSHS hearing rules.

FOR AGENCY USE ONLY

☐ **Oral request taken by:**

NAME | TELEPHONE NUMBER

INVOLVED DIVISION/ORGANIZATION

MAIL TO: OFFICE OF ADMINISTRATIVE HEARING (OAH), MAIL STOP: 42489
PO BOX 42489
OLYMPIA WA 98504-2489

FAX: 360-586-6563

I request a hearing because I disagree with the following service decision by the Division of Developmental Disabilities (DDD):

YOUR NAME (PLEASE PRINT)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS OF PERSON REQUESTING HEARING	CLIENT ID NUMBER	
CITY STATE ZIP CODE	TELEPHONE NUMBER (INCLUDE AREA CODE) ☐ **MESSAGE PHONE**	

I was notified of the decision on: _____ by: _____
DATE DSHS OFFICE NAME AND LOCATION

I want continued assistance, if I am eligible: ☐ **Yes** ☐ **No** Program: _____

I am represented by (if you are going to represent yourself, do not fill in the next two lines):

YOUR REPRESENTATIVE'S NAME	ORGANIZATION	TELEPHONE NUMBER
ADDRESS CITY STATE ZIP CODE		

☐ **I authorize release of information about my hearing to my representative.**

YOUR SIGNATURE	DATE

Do you need an interpreter or other assistance or accommodation for the hearing? ☐ **Yes** ☐ **No**

If yes, what language or what assistance? _____

Administrative Law Judges (ALJ's) may hold some hearings by telephone. If you want to change to an in-person hearing, follow the instructions in the Notice of Hearing that will be mailed to you by OAH.

DDD WAIVER ENROLLMENT AND TERMINATION PLANNED ACTION NOTICE INSTRUCTIONS

Completing the Form

1. Waiver Enrollment:

   - The effective date of the waiver enrollment on the first page of the Planned Action Notice is the date the Case Resource Manager signs the Plan of Care (POC). Remember: All of the items must be completed on the Waiver Eligibility Determination Checklist (10-274) before you can sign the POC.

2. Waiver Termination:

   - The effective date of the termination for waiver eligibility and services on the first page of the Planned Action Notice is a minimum of 10 days from the mailing of the Planned Action Notice then extending to the end of the month of the tenth day.
   - When the client is moving from one waiver to another the termination date is the day before the waiver enrollment effective date.

3. It is preferable that any:

   - Service termination occurs the last day of the month, and
   - Service reduction occurs the first day of the month.

4. The appeal date on the second page of the Planned Action Notice is calculated by counting ten (10) days from the date of mailing - the tenth day must be a working day - and extending to the end of the month.

   - Services continue if an appeal is filed in a timely manner except for circumstances listed in WAC 388-825-150.

5. The client is instructed to return the form if they choose NOT to have services or eligibility continue during the appeal. If they choose to contact you by telephone, note that they have requested to discontinue services in the CARE SER and terminate services the same date as the termination effective date on the first page.